

NOTICE OF INDEPENDENT REVIEW DECISION

March 28, 2003

RE: MDR Tracking #: M2-03-0550-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ___ when he injured his lower back. The patient was evaluated and was recommended to undergo electromyography, a discogram, epidural steroid injections, and physical therapy. An MRI performed on 05/04/01 revealed L4-5 broad disc protrusion, annular tear, and L5-S1 arthropathy. The patient underwent a discogram with CT scan on 11/14/01 that revealed annular tears and disc herniations at L3-4 and L4-5. The patient underwent an annuloplasty on 02/13/02. The patient continues to complain of pain with lumbar extension and the treating physician has recommended that the patient under lumbar facet medial branch blocks with fluoroscopy and sedation.

Requested Service(s)

Lumbar facet medial branch blocks with fluoroscopy and sedation

Decision

It is determined that the lumbar facet medial branch blocks with fluoroscopy and sedation are medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has chronic low back pain that is worse with extension (characteristic of facet pain) and has not responded to time, medication including narcotics, spine rehabilitation, epidural steroid injections, and nucleoplasty. The physician states that the injections are to be done on a diagnostic basis to determine if the patient is a candidate for facet neurectomy, which has been shown to clearly be useful in patients with facet joint pain. The North American Spine Society Guidelines include facet injections at this stage of pain (phase 3). Medicare Local Medical Review Policy Guidelines approve facet injections to help identify the source of pain. The Agency for Healthcare Research and Quality Guidelines state "facet injections should be reserved for those who fail to respond to directed conservative care for at least 4 weeks". Therefore, the lumbar facet medial branch blocks with fluoroscopy and sedation are medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 28 th day of March 2003. :
